STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G265	A. BUILDING 01 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 07/20/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/15/11 Facility Number: 000785 Provider Number: 15G265 AIM Number: 100249010 Surveyor: Bridget Brown, Life Safety Code Specialist At this PSR survey, REM-Indiana Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two story facility with a basement was fully sprinklered.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility has a fire alarm system with smoke detection on all levels including corridors, common living areas and sleeping rooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.9. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/20/11. This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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KS017	The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2. Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4. Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4. Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping. Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety,			

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	sleeping rooms are separated from escape routes by walls and doors that are smoke resistant. No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.			
	Based on observation and interview, the facility failed to provide smoke resistant doors to 1 of 6 second floor sleeping rooms. LSC 8.2.4.3.4 requires smoke barrier door clearance be in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Windows. NFPA 80, Section 2-3.1.7 requires the distance between the edge of the door and the frame not exceed 1/8 inch for wood doors. This deficient practice affects all occupants. Findings include: Based on observation with the program director on 09/15/11 at 1:50 p.m., the center second floor sleeping room door gapped 1/2 inch between the top of the door and the door frame. The program director said at the time of observation, the door had been repaired to make sure it latched	KS017	The facility provides smoke resistant doors to all sleeping rooms. The facility has contracted a vendor to fix and replace any doors to sleeping rooms that do not latch, or fit the standard to not exceed a 1/8 inch gap for wood doors. All sleeping room doors have been checked and repaired if needed. The Program Director has trained the Home Manager on the standard for sleeping room doors. The Home Manager will check all sleeping room doors, at least monthly, and will document this on the Home Manager checklist. This checklist will be submitted to the Program Director monthly. The Program Director will review to verify any needed corrective action plans that may need follow up. Person Responsible: Program Director, Home Manager Date completed: 9/30/11	09/30/2011

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	and she didn't notice the gap. This deficiency was cited on 07/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			
KS018	Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 6 second floor sleeping room doors was equipped with a working latch to keep the door closed. This deficient practice affects all occupants. Findings include: Based on observation with the program director on 09/15/11 at 1:45 p.m., the second floor	KS018	The facility provides smoke resistant doors to all sleeping rooms. The facility ensures that all sleeping room doors are equiped with working latches. The facility has contracted a vendor to fix and replace any doors to sleeping rooms that do not latch, or fit the standard to not exceed a 1/8 inch gap for wood doors. All sleeping room doors have been checked and repaired if needed.The Program Director has trained the Home Manager on the standard for sleeping room doors. The Home Manager will check all sleeping room doors, at least monthly, and will document	09/30/2011

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	sleeping room near the east stairway had a door which did not latch. The door could be pushed gently and opened without turning the doorknob. The program director said she was unaware the door did not latch. It was a new door and she expected it would work. This deficiency was cited on 07/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.		this on the Home Manager checklist. This checklist will be submitted to the Program Director monthly. The Program Director will review to verify any needed corrective action plans that may need follow up.Person Responsible: Program Director, Home ManagerDate completed: 9/30/11	